BEFORE THE DIVISION OF INSURANCE

STATE OF COLORADO

FINAL AGENCY ORDER O-10-088

IN THE MATTER OF THE MARKET CONDUCT EXAMINATION OF AETNA HEALTH INC.

Respondent

THIS MATTER comes before the Colorado Commissioner of Insurance (the "Commissioner") as a result of a market conduct examination conducted by the Colorado Division of Insurance (the "Division") of Aetna Health, Inc. (the "Respondent"), pursuant to §§ 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-416, C.R.S. The Commissioner has considered and reviewed the market conduct examination report dated October 15, 2009 (the "Report"), relevant examiners' work papers, all written submissions and rebuttals, and the recommendations of staff. The Commissioner finds and orders as follows:

FINDINGS OF FACT

1. At all relevant times, the Respondent was licensed by the Division as a health maintenance organization.

2. In accordance with §§ 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-416, C.R.S., on October 15, 2009, the Division completed a market conduct examination of the Respondent. The period of examination was January 1, 2008 to December 31, 2008.

3. In scheduling the market conduct examination and in determining its nature and scope, the Commissioner considered such matters as complaint analyses, underwriting and claims practices, pricing, product solicitation, policy form compliance, market share analyses, and other criteria as set forth in the most recent available edition of the Market Regulation Handbook adopted by the National Association of Insurance Commissioners, as required by § 10-1-203(1), C.R.S.

4. In conducting the examination, the examiners observed those guidelines and procedures set forth in the most recent available edition of the Market Regulation Handbook adopted by the National Association of Insurance Commissioners and the Colorado insurance examiners' handbook. The Commissioner also employed other guidelines and procedures that she deemed appropriate, pursuant to § 10-1-204(1), C.R.S.

5. The market conduct examiners prepared a Report. The Report is comprised of only the facts appearing upon the books, records, or other documents of the Respondent, its agents or other persons examined concerning Respondent's affairs. The Report contains the conclusions and recommendations that the examiners find reasonably warranted based upon the facts.

6. Respondent delivered to the Division written submissions and rebuttals to the Report.

7. The Commissioner has fully considered and reviewed the Report, all of Respondent's submissions and rebuttals, and all relevant portions of the examiners' work papers.

CONCLUSIONS OF LAW AND ORDER

8. Unless expressly modified in this Final Agency Order ("Order"), the Commissioner adopts the facts, conclusions and recommendations contained in the Report. A copy of the Report is attached to the Order and is incorporated by reference.

9. Issue A1 concerns the following violation: Failure to include some required provisions in HMO provider contracts. The Respondent shall provide evidence to the Division that it has revised all applicable provider contracts to include all provisions required by Colorado insurance law.

10. Issue A2 concerns the following violation: Failure, in some instances, to maintain records required for market conduct purposes. The Respondent shall provide evidence to the Division that it has revised its internal procedures and systems so that all claims records are retained, can be correctly identified and can be made available for review as required Colorado insurance law.

11. Issue E1 concerns the following violation: Failure, in some instances, to provide HMO contact information in evidence of coverage forms. The Respondent shall provide evidence to the Division that it has revised all applicable forms to provide a toll free or collect call telephone number of the HMO within the service area for calls to the HMO administrative office, without charge to enrollees, to ensure compliance Colorado insurance law. The Respondent has indicated that it has complied with the corrective actions ordered concerning this violation.

12. Issue E2 concerns the following violation: Failure, in some instances, to provide accurate information regarding Newborn and Adoptive Child Enrollment. The Respondent shall provide evidence to the division that the

Company's HMO Certificate of Coverage form has been revised to provide accurate information regarding enrollment of newborn and newly adopted dependents as required by Colorado insurance law. The Respondent has indicated that it has complied with the corrective actions ordered concerning this violation.

13. Issue E3 concerns the following violation: Failure, in some instances, to provide accurate information regarding coverage for dependents to age twenty-five. The Respondent shall provide evidence to the Division that it has revised all affected forms to include accurate information regarding the offer of coverage for dependents up to age twenty-five, to ensure compliance with Colorado insurance law. The Respondent has indicated that it has complied with the corrective actions ordered concerning this violation.

14. Issue E4 concerns the following violation: Failure, in some instances, to provide accurate information regarding the responsibility for tracking co-payments. The Respondent shall provide evidence to the Division that is has revised its schedule of benefits to indicate that it is the Company's responsibility to properly track member co-payments, in compliance with Colorado insurance law. The Respondent has indicated that it has complied with the corrective actions ordered concerning this violation.

15. Issue E5 concerns the following violation: Failure to provide a required Disclosure Notice in the HMO Certificate of coverage Form. The Respondent shall provide evidence to the Division that it has revised its HMO Certificate of Coverage Form to provide all information required in the disclosure notice regarding network adequacy as required by Colorado insurance law. The Respondent has indicated that it has complied with the corrective actions ordered concerning this violation.

16. Issue E6 concerns the following violation: Failure, in some instances, to provide for coverage to continue after refusal of treatment recommended by a participating provider. *(This was prior issue E3 in the findings of the 2002 final examination report.)* The Respondent shall provide evidence to the Division that it has revised all applicable forms to remove the provision that ends coverage if treatment is refused and ensures that coverage continues in that event as required by Colorado insurance law.

    In the market conduct examination for the period January 1, 2002 to December 31, 2002, the Company was cited for failure to provide for continued coverage of a condition after a member has refused a recommended treatment or procedure. The violation resulted in Recommendation #13 of the Final Agency Order O-05-002 that the Company "shall provide evidence that it has revised all affected forms to provide for continued coverage of a condition regardless of whether or not a

member has refused a recommended procedure or treatment to ensure compliance with Colorado insurance law." Failure to comply with the previous order of the Commissioner may constitute a willful violation of §10-1-205, C.R.S.

17. Issue E7 concerns the following violation: Failure, in some instances, to provide accurate information regarding coverage for therapies for congenital defects and birth abnormalities. The Respondent shall provide evidence to the Division that has revised all forms to reflect the correct age for a covered dependent related to therapies for congenital defects and birth abnormalities as required by Colorado insurance law. A self audit should also be performed to properly pay claims for therapies for congenital defects and birth abnormalities.

18. Issue E8 concerns the following violation: Failure, in some instances, to proscribe the use of genetic testing in connection with a pre-existing condition. The Respondent shall provide evidence to the Division that has revised all applicable forms to proscribe the use of genetic information to determine a pre-existing condition if there is a diagnosis of the condition related to the information, as required under Colorado insurance law.

19. Issue E9 concerns the following violation: Failure to correctly define a significant break in coverage in the Certificate of Coverage forms. The Respondent shall provide evidence to the Division that has revised its forms to correctly define a significant break in coverage as required by Colorado insurance law. The Respondent has indicated that it has complied with the corrective actions ordered concerning this violation.

20. Issue E10 concerns the following violation: Failure to correctly state the member's responsibility for payment of charges for non-covered services for which there was a referral in the Certificate of Coverage form. The Respondent shall provide evidence to the Division that has revised its certificates of coverage to prohibit billing of a covered person for services received in connection with a referral by a participating provider as required by Colorado insurance law. The Respondent has indicated that it has complied with the corrective actions ordered concerning this violation.

21. Issue E11 concerns the following violation: Failure, in some instances, to provide accurate information regarding conversion of insurance. The Respondent shall provide evidence to the Division that has revised its certificates of coverage to provide for conversion of insurance for Members who are eligible, but not actually covered by Medicare as required by Colorado insurance law. The Respondent has indicated that it has complied with the corrective actions ordered concerning this violation.

22. Issue H1 concerns the following violation: Failure to reflect a complete definition of a "significant break in coverage" in certificate of creditable coverage. The Respondent shall provide evidence to the Division that has implemented procedures to ensure that all Certificate of Creditable Coverage reflect the complete definition of "Significant break in coverage" in compliance with Colorado insurance law. The Respondent has indicated that it has complied with the corrective actions ordered concerning this violation.

23. Issue J1 concerns the following violation: Failure, in some instances, to pay, deny or settle claims within the time periods required by Colorado insurance law. The Respondent shall provide evidence to the Division that has reviewed and modified its claims processing quality controls to ensure that all claims are adjudicated within the required time periods as required by Colorado insurance law.

24. Issue J2 concerns the following violation: Failure, in some instances, to pay late payment interest and/or penalties on claims not processed within the required time periods. The Respondent shall provide evidence to the Division that has implemented procedures to ensure that correct late payment penalties are paid in all applicable instances as required by Colorado insurance law. A self audit should also be performed to properly pay all late payment penalties owed.

25. Issue J3 concerns the following violation: Failure, in some cases, to send a written explanation within thirty (30) calendar days after receipt of an unclean claim, and/or failure to give a full and correct explanation of what additional information is needed to resolve the claim. The Respondent shall provide evidence to the Division that has implemented procedures to ensure that a request for additional information is sent as required by Colorado insurance law.

26. Issue J4 concerns the following violation: Failure, in some cases, to provide true and accurate statements in provider and/or member notices regarding the reasons claims were denied. The Respondent shall provide evidence to the Division that has revised its claim payment procedures to ensure that accurate information regarding the reason(s) a claim was denied is provided to both providers and members. The Respondent has indicated that it has complied with the corrective actions ordered concerning this violation.

27. Issue J5 concerns the following violation: Failure, in some instances, to pay eligible charges on claims. The Respondent shall provide evidence to the Division that has revised its claim payment procedures to ensure that all eligible charges are paid when due. The Company should also be required to perform a self audit of all claim denials to ensure that any eligible

charges that were not incorrectly denied are paid.

28. Issue K1 concerns the following violation: Failure, in some instances, to provide a written notice to the covered person at least twenty (20) calendar days prior to the scheduled review date. The Respondent shall provide evidence to the Division that has implemented procedures to ensure that notice of all second level review meetings are provided at least twenty (20) calendar days in advance of the review date.

29. Issue K2 concerns the following violation: Failure, in some instances, to ensure that the second level review panel is comprised of health care professionals with the appropriate expertise in relation to the case being presented. The Respondent shall provide evidence to the Division that has revised its procedures to ensure that all second level review panels are comprised of health care professionals with the appropriate expertise in relation to the case being presented.

30. Issue K3 concerns the following violation: Failure, in some instances, to include the names, titles or qualifying credentials of the reviewer or members of the review panel in the Company's second level review decision notification letter. The Respondent shall provide evidence to the Division that has revised its second level review decision notification letter and/or attachment provided to the covered person and/or their representative(s), to provide the names, titles or qualifying credentials of the reviewer or members of the review panel as required by Colorado insurance law.

31. Issue K4 concerns the following violation: Failure, in some instances, to demonstrate an understanding of a covered person's request for review, and failure to provide the procedures for obtaining an independent external review of an adverse determination. The Respondent shall provide evidence to the Division that has revised its procedures to ensure that the Company demonstrates an understanding of the covered person's request for review, and provides the procedures for obtaining an independent external review of an adverse determination as required by Colorado insurance law.

32. Issue K5 concerns the following violation: Failure, in some instances, to include name, title, and qualifying credentials of the physician who evaluated the appeal and/or the qualifying credentials of the clinical peer(s) with whom the physician consulted in first level review decision letters. *(This was prior issue K8 in the findings of the 2002 examination report and K3 in the previous 200 final examination report.)* The Respondent shall provide evidence to the Division that has revised its procedures to include the name, title and qualifying credentials of the physician who evaluated the appeal and/or the qualifying credentials of the clinical peer(s) with whom the

physician consults as required by Colorado insurance law.

The market conduct examinations calendar years 1998 and 2002, the Company was cited for failure to include all required information in written notification letters sent to members and providers regarding first level reviews. These violations resulted in Recommendation #59 of Final Agency Order O-00-293, and #29 of the Final Agency Order O-05-002 that the Company "shall provide evidence that is has revised its procedures to ensure that level one written notification letters contain all required information as required by Colorado insurance law." Failure to comply with the previous orders of the Commissioner may constitute willful violation of § 10-1-205, C.R.S.

33. Issue K6 concerns the following violation: Failure, in some instances, to include a consultation with an appropriate clinical peer when evaluating first level review appeals. The Respondent shall provide evidence to the Division that has revised its procedures to include a consultation with an appropriate clinical peer when evaluating first level review appeals, unless the reviewing physician is a clinical peer as required by Colorado insurance law.

34. Pursuant to § 10-1-205(3)(d), C.R.S, the Respondent shall pay a civil penalty to the Division in the amount of Two Hundred Ninety-Four Thousand and no/100 dollars ($294,000.00) for the cited violations of Colorado law. This fine was calculated in accordance with Division guidelines for assessing penalties and fines, including Division Bulletin No. B-1.3, originally issued on January 1, 1998, re-issued May 8, 2007. Said penalty shall be assessed a 10% surcharge up to $200,000, or $20,000.00, pursuant to 24-34-108, C.R.S. for a total balance due of $314,000.00 which will be due to the Division within 30 days of the signing of this Final Agency Order. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program.

35. Pursuant to § 10-1-205(4)(a), C.R.S., within sixty (60) days of the date of this Order, the Respondent shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related Order.

36. Unless otherwise specified in this Order, all requirements with this Order shall be completed within thirty (30) calendar days of the date of this Order. Respondent shall submit written evidence of compliance with all requirements to the Division within the thirty (30) calendar day time frame, except where Respondent has already complied, as specifically noted in the Order. Forms violations may be corrected by revising the appropriate noncompliant area(s) of the forms, or by issuing an addendum to correct the noncompliant areas if the Company is unable to correct the actual form within the required time period. Copies of any rate and form filings shall be provided to the rate and forms section with evidence of the filings sent to the market conduct section. All self audits, if any, shall be performed in accordance with Division's document, 'Guidelines for Self Audits Performed by Companies', Unless otherwise specified in this Order, all self audit reports must be received within ninety (90) days of the Order, including a summary of the findings and all monetary payments to covered persons.

37. This Order shall not prevent the Division from commencing future agency action relating to conduct of the Respondent not specifically addressed in the Report, not resolved according to the terms and conditions in this Order, or occurring before or after the examination period. Failure by the Respondent to comply with the terms of this Order may result in additional actions, penalties and sanctions, as provided for by law.

38. Copies of the examination report, and this final Order will be made available to the public no earlier than thirty (30) calendar days after the date of this Order, subject to the requirements of § 10-1-205, C.R.S.

WHEREFORE: It is hereby ordered that the findings and conclusions contained in the Report dated October 15, 2009, are hereby adopted and filed and made an official record of this office, and the above Order is hereby approved this 16th day of February, 2010.

Marcy Morrison
Commissioner of Insurance

CERTIFICATE OF MAILING

I hereby certify that on the 16th day of February, 2010, I caused to be deposited the **FINAL AGENCY ORDER NO. O-10-088 IN THE MATTER OF THE MARKET CONDUCT EXAMINATION OF AETNA HEALTH INC.,** in the United States Mail via certified mailing with postage affixed and addressed to:

Allan I. Greenberg
Aetna Health, Inc.
6501 S. Fiddler's Green Circle
Greenwood Village, CO 80111

Eleanor Patterson
Market Regulation Administrator
Division of Insurance